Medication Free Treatment Programme

Treatment without the use of neuroleptics for people
with severe mental health conditions
at the University Hospital of Northern Norway

Tromsø
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PSICHIKOS
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Introduction

The University Hospital in Northern Norway saw considerable national and international attention regarding the establishment of a medication-free treatment programme at the hospital in January 2017. This was due to several factors, but not least the fact that there had been no such treatment options within the framework of traditional public psychiatric hospitals or clinics anywhere else around the world, up to that point.

The unit experienced a number of enquiries from the start, from users of mental health services, as well as professionals who wanted to visit the unit. Some just came to see it, while others came to consider the possibility of cooperating with the unit in various ways.

In December 2019, the head of the psychiatric association in Lithuania, Ramunė Mazaliauskienė, contacted the unit asking if a few of her colleagues from the NGO Mental Health Perspectives (www.perspektyvos.org) – Karilė Levickaitė, Ugnė Grigaitė and Aurelija Auškalnytė – could visit to explore the medication-free treatment programme. Thus, a collaboration on a project funded by the Active Citizens Fund, and called "Wings of Change" began, promoting human rights and social inclusion of people with psychosocial or/and intellectual disabilities, in Lithuania and beyond.

Tromsø, June 2021

How the Norwegian Healthcare System is Organised

In Norway, public social security and social insurance are called the National Insurance Scheme. You must be a member of the National Insurance Scheme to be entitled to benefits under the National Insurance Act. As a member of the Scheme, you get access to all public health and care services. As a general rule, everyone who resides or works legally in Norway is a member of the National Insurance Scheme. This means the vast majority of people living in Norway have access to free and equal health services, regardless of their place of residence and level of income.

The Norwegian healthcare system is partially decentralised. The responsibility for specialized treatment lies with the state. There are four regional health trusts around the country, one for each major geographical region, that are responsible for providing specialist healthcare services for the population of their health region. They also own the public hospitals in the region. The public hospitals are organised as health trusts, which are managed by the regional health trusts.

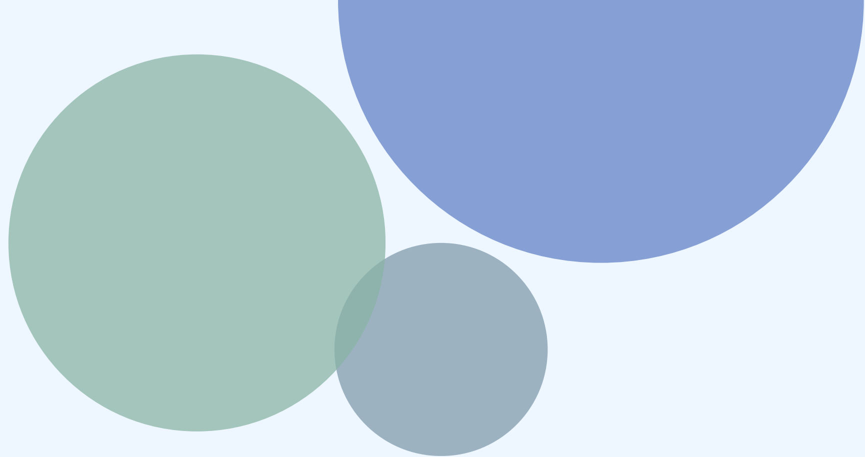
Municipalities are responsible for the primary health and care services. In primary health care, the general practitioner is the patient's most important and first contact with the healthcare services. Everyone has the right to be assigned or choose a family doctor. General practitioner offers daytime healthcare services for people on their patients' list. This also includes emergency healthcare. The general practitioner also cooperates with other services within primary health and care services, as well as social services, when there is a need for such cooperation with regards to the persons on their lists. This collaboration may include home-based services, nursing homes for admission and discharge, child health clinics and health stations, municipal drug addiction care services, etc. The general practitioner plays an important role in coordinating responses to the patient's needs for medical services.

Depending on the patient's needs for treatment or help, a general practitioner can refer a patient for necessary health care. A patient who needs to be examined and/or treated by a specialized health service for an illness can be referred to a specialist. These can be private contract specialists, specialists with hospice expertise at a district medical centre, at a decentralised outpatient clinic or specialists at outpatient clinics at hospitals.

A person in need of treatment within the mental health care system may be referred to a district psychiatric centre. These offer specialised services in mental health care and can also admit patients for daytime treatment or hospitalisation. People with serious and acute psychiatric conditions are admitted to emergency departments at hospitals. Patients with substance use problems may be referred for outpatient treatment or hospitalisation at a substance abuse institution.

For conditions (both mental health and somatic) that require hospitalisation, the patient is referred to a hospital. The patient can choose which hospital one prefers through a scheme called free hospital choice. This includes private hospitals that have an agreement with the regional health authorities as well. Due to the fact that hospitals often become more specialised in certain medical spheres, the tasks are often shared between the hospitals.

The unit follows the general rule that treatment of mental health conditions is voluntary. Patients who are admitted to an institution have the right to leave the institution whenever they wish. Patients who are admitted voluntarily cannot be medicated without their consent.



The Mental Health Care Act also allows for patients to be subject to compulsory mental health care when certain conditions are met. This can be carried out in three ways: inpatient, outpatient with compulsory treatment, and compulsory observation which means that the patient can be detained in the hospital for up to 10 days so the hospital can assess the conditions for compulsory mental health care. Pursuant to the law, decisions can also be made on more intrusive measures such as protection, coercive measures, and coercive medication.

Medication-free Treatment is part of the specialist health services, i.e. the state's responsibility. Patients who would like to receive treatment at the unit must be referred to it by a therapist from an outpatient department of a specialist health service (most often from a district psychiatric centre). This presupposes a referral from a general practitioner. As mentioned before, to get the referral from a general practitioner and thus receive treatment at our unit you must live in Norway. Our Medication-free Treatment Programme is voluntary. This means the patients themselves must want treatment and have the right to terminate treatment whenever they want.

Reasons for Offering Medication-free Services in Norway

In 2015, the Ministry of Health and Care Services (HoD) sent out a document in which they instructed all regional health trusts in Norway to establish their own medication-free units (HoD, 2015). The demand came about after several user organisations had joined forces in a collaboration, they called the Joint Action for Medication Free Treatment (Fellesaksjonen, 2013). The goal of this collaboration was for real medication-free treatment alternatives to become available at public specialist health services, especially for people with severe mental health conditions. The user organisations shared their experiences and stories on how people with diagnoses of psychosis and bipolar disorder in particular were pressured to take neuroleptics, and that there were few real opportunities or alternatives for other types of treatment. The basic document issued by the Joint Action stated that people who want medication-free treatment often have no inpatient services available at psychiatric hospitals, and that this should be available on the basis of their freedom to choose treatment that they personally believe in and prefer.

The Joint Action called for setting up services where people were not subjected to compulsory medication or pressured to take medication, where treatment was based on creating a safe place to be, and to gather experiences to develop good treatment cultures for non-drug treatment that could strengthen the field's need for knowledge and development.

Medication-free Treatment programme offered by the University Hospital of Northern Norway opened in January 2017. The debate that followed around medication-free treatment of psychosis and bipolar disorder has been extensive and interesting to follow.

It has created commitment in many areas. Key topics have revolved around issues related to the knowledge base for efficacy and risk related especially to long-term treatment with neuroleptics and the professional soundness of medication-free treatment for psychosis and bipolar disorder.

Regarding professional soundness, the Norwegian Directorate of Health (2017) has specified that if the patient can give fully informed consent, treatment should be voluntary and the patient thus has the right to participate in choosing between sound treatment options. What professionally sound means, is an assessment that includes evaluation of factors about the patient, the treatment offered and the circumstances of the situation. When the medication-free treatment programme was getting started in Norway, the debate initially appeared to be polarised between different opinions about what is the best treatment for severe mental health conditions. Some thought that medication-free treatment was unjustifiable, experimental and thoughtless. Gradually, there was a growing acceptance that there is evidence for different treatment approaches, and that the introduction of medication free treatment options primarily concerned patient's right to autonomy, participation and making informed choices about one's own life.

Medication-free treatment is thus more about human rights, user participation and the right to make informed choices about one's own treatment, than about the effect of different treatment approaches.

When the Minister of Health Bent Høie cut the cord at the official opening of the Medication Free Treatment unit on 31st January 2017, he said that the introduction of medication free services in the public health services in Norway would help to make healthcare services even better by meeting patients' needs. Now they could be considered experts of their own health and decide which treatment they want, even if it does not involve medication and the use of neuroleptics.

Development of the Medication Free Treatment (MFBT) at the University Hospital of Northern Norway (UNN)

Following the request from HoD, a protocol group was established at the northernmost health trust, consisting of representatives from various user organizations and professionals from UNN. The protocol established a framework for medication-free options, which was described in the following main features:

- The medication free option was to be established as an inpatient unit with 4 – 6 beds. The offer was to be a regional offer for the Northern Norway Health Trust (Helse Nord), and the target group was to be people with severe mental health conditions, primarily psychosis or bipolar disorder, who wanted medication free treatment.
- The medication free unit was to be based on Norwegian health legislation and national professional guidelines – in line with other treatment options in the specialist health services.
- The service should be based on the Joint Action's basic ideas and recommendations.
- The service was to be completely voluntary, increase the freedom of choice for patients and be part of a larger investment in medication-free treatment and reduction of unnecessary use of medication in mental health care.
- It was to be run as a recovery-based option.

After the framework was approved, it was up to the unit itself to develop the programme further. The assignment from HoD stated that the service offer should be designed in close collaboration with user organizations; MFBT solved this by establishing a collaboration group that consisted of employees from MFBT and representatives from various user organizations. The collaboration group met regularly during the first year, and had an advisory function in the development of this treatment option. For MFBT, it was important to strive for the integration of the basic ideas from the Joint Action (Fellesaksjonen, 2013) with Norwegian health legislation and national professional guidelines as the legal basis (Norwegian Directorate of Health, 2013) in line with other treatment

options within the specialist health services. It was decided that the Inpatient Department would be located in Tromsø and accommodate 6 inpatient clients.

The unit's personnel are organised in a similar way to most other inpatient units in Norway, with a staffing factor similar to an emergency unit. There are 24 employees at the unit, who are trained nurses, occupational therapists, social workers, occupational therapists physiotherapists, milieu therapists, experience consultants, psychologists, doctors and chief physicians. Most people, who work at the unit, have different higher education specialisations or are still studying at the higher education level, in various fields.

Therefore, there is expertise in various therapeutic directions: art and expression therapy, individual Placement and Support (IPS) and psychomotor/physical understanding. A lived-experience consultant is employed at the unit; this position is also a part of the unit's management team. This has been useful for promoting understanding of experiential competence at the unit, which has contributed to a practice that transcends the 'user participation'. From the user organisations, lived-experience competences among employees were desirable. In the recruitment process, when the programme was being set up, personal lived-experience of employees was considered a valued competence.

To work at the unit, there was a prerequisite for candidates to believe that medication free treatment has a value in itself, and that they want to work with just that. The prerequisite for this was to establish a completely new department where everyone who wanted to work there had to apply. This contributed to establishing a completely new professional environment within the medication free treatment, and also an important spearhead in the work of session experience and increasing the knowledge base. Elsewhere in Norway, this was not possible, as other hospitals chose to solve the assignment from HoD differently; for example, by dedicating one bed in an already existing inpatient unit to medication free treatment.

Course of Treatment, Medication Free Treatment

Course of treatment. This is a course of treatment, which consists of collaboration between several agencies and often several admissions at MBFT over time. The district psychiatric centre and municipal services run the primary care side of the programme. A private network and team at MFBT will support the programme, in the form of admissions and collaboration via network meetings, guidance, etc.

This means medication free treatment is not only something that happens with a limited admission to the hospital unit, but simultaneously in several parts of the patients' treatment network.

This enables long-term processes, preferably over several years, without the patient having to be hospitalised during the whole period. In the period between referral and first admission to MFBT, an overall comprehensive treatment plan is offered by the network, where admissions to MFBT are part of the process. Frequency, length and treatment focus at admission vary based on the patient's wishes and needs, and what comes up with during a dialogue within the network. An average course lasts about 2-3 years and consists of outpatient treatment at the district psychiatric centre and 4 – 6 planned admissions per year at the unit for post drug-free treatment. A flexible approach is sought so that, as far as possible, it is not the patients who have to adapt to MFBT, but MFBT is adapted to each patient individually.

Patients who apply for MFBT believe that recovery is possible without the use of neuroleptics. Many patients need assistance in tapering medications after long-term use of neuroleptics. The treatment goal for patients is often the opportunity to explore other ways of working with and dealing with their mental health and social challenges. This often involves raising awareness about processes that lead to challenges, as well as exploring and testing alternative ways of dealing with them.

As life must be lived at home and in one's own immediate environment, this is also a key factor leading to the programme being organised as a process. It is at home that life is lived, where you experience challenges when tapering or stopping medications. Therefore, new ways of behaving must also be anchored in the process and tested out in this environment. Even though recovery feels personal and individual, it is also a social process. That is why it is important to have good support from your local network, when embarking on a long-term project such as managing to live without medication when struggling with symptoms of psychosis or bipolar disorder.

The protocol group described how the treatment should be based on values related specifically to recovery and be based on relationships and networks.

Recovery anchoring. Our understanding of the concept of recovery is that in a recovery-based health service the focus shifts from the health condition to resources and opportunities. This means more than emphasising the latter.

MFBT's understanding of the concept of recovery within a relational and network perspective means that various mental health conditions are understood more as reactions to the lived life than as medical problems, and that the treatment is about learning to deal with various challenges as opposed to reducing, alleviating and curbing symptoms.

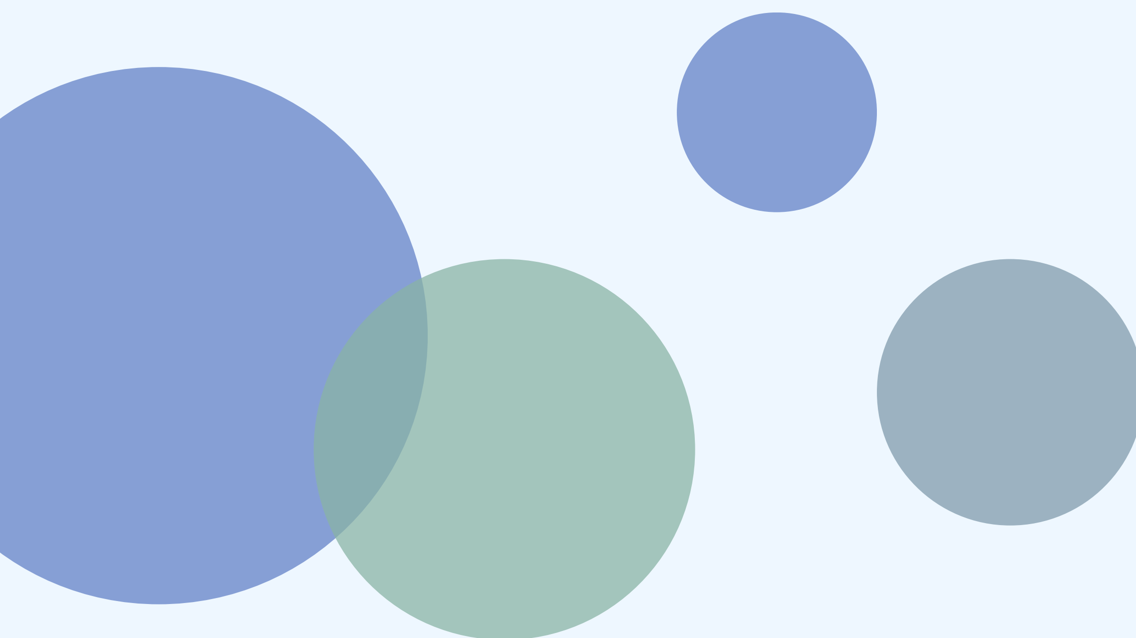
Changing one's relationship with what is happening, as opposed to controlling what is happening, is a key change mechanism in line with most recent psychotherapeutic treatment methods such as Acceptance and Commitment Therapy (Hayes, Strosahl and Wilson, 2011) and metacognitive therapy (Wells, 2007). This is anchored in the patient's everyday life and network, by involving important relationships in the process of the individual person.

A relationship and network perspective. Learning to get by without medication when you have serious mental health conditions is often a long and demanding process that requires individual adaptation. It is important

that the treatment approach reflects this. Therefore, the starting point for MFBT, when a person is referred to the unit, is creating a treatment offer in dialogue between the person concerned and important people in one’s life.

From a relational and networking perspective, mental health conditions are not something that occur inside a person, but between people. That is, mental health challenges are often experienced in meaningful relationships. This is the reason why, within this perspective, emphasis is placed on seeking understanding and solutions to the challenges of relationships. The approach involves collaborating with each patient's network. Networking approaches help create the sense of belonging and community around something that is close to the patient's life.

Belonging and a sense of community arise when people who are important to each other come together; if something has a huge driving force in the recovery processes. These factors contribute to the reduction of difference, exclusion, stigma, diminished autonomy, existential anxiety and shame, which in many cases prove to be key challenges for patients within the medication free treatment programme of the MFBT.



Recovery Promoting Measures within the Treatment Programme

The unit has placed emphasis on facilitating measures and actions that are in line with recovery values, and that can promote sustainable change processes. The majority of the patients who are on a medication free programme have previously experienced compulsory treatment in mental health care, both in the form of hospitalisations and compulsory medication use. Experience from the unit shows that measures where patient's autonomy is promoted in a fundamental way are of great importance in improvement processes. The rest of this document describes our key practices in medicine free treatment.

Self-referral. Our patients are asked to write a self-referral, where the purpose from the start is to bring out the patient's thoughts and opinions. This emphasises that MFBT is a voluntary treatment programme that requires motivation and commitment from the patient. Furthermore, the self-referral contributes to the patient starting the treatment process at home with their family, therapist and network to anchor the process in their lives, where they live on a daily basis. In the self-referral, the patient describes the reasons for the desire for medication free treatment, previous experiences with treatment, recovery goals and what interests one has.

Network meetings. An initial network meeting is planned after the referral has been received and it has been assessed that the patient falls within the target group for medication free treatment. The patient is referred to the meeting and asked to join along with others whom one wants to include. This can be family members, follow-up services, a family doctor or others who have an important place in the patient's network. Throughout the process, regular network meetings are held to ensure good collaboration and to follow-up about the treatment of each patient. A network meeting is more than a traditional collaboration meeting where different tasks are distributed and information is shared. Network meetings are, among other things, a central and important arena in the treatment processes where a common understanding of the recovery process is established by the group, and important decisions are made, often with the use of reflective conversations or elements known from open dialogue practices.

Team meetings. Each patient gets his or her own team at MFBT. This team consists of 3 MFBT employees and a patient. Doctors/chief physicians participate in the team meetings if there is a need for that when they themselves are not therapists in relevant teams. During hospitalisation periods team meetings are held approximately once a week. The patient always participates in a team meeting. The purpose of the meeting is to plan, evaluate and make adjustments to the admission, as well as have a dialogue about the team if the patient or other team member thinks is important.

Nothing about me without me. The unit strives not to have conversations or meetings about the patient that involve making decisions, or understanding/interpreting the patient's behaviour/condition, without the patient being present. This means that the patient participates in all of the treatment meetings etc. that deal with patient’s matters.

Self-documentation. Norwegian health personnel follow strict requirements for documentation and record keeping of treatments. Both a continuous environmental journal and a case summary are written for treatment. Self-documentation is an offer the patient receives to write their own medical notes in the same way as health personnel. Notes that the patients write themselves become part of the patient's records, together with other notes. Patients at the hospital have full access to their own medical records and can log in via an electronic solution and continuously read the medical records that are written about them by healthcare professionals.

Reflective conversations. In some processes, reflective conversations are used, a method developed by psychiatrist Tom Andersen in the 1980s. The reason for developing this method was a comprehensive focus on the pathology, and a desire to develop an approach that emphasised interpersonal recognition. The method means that the therapists do not take on an expert role with a final answer, but rather facilitate patients to find solutions themselves by participating in open dialogue, reflection and being in a listening position. This is consistent with our treatment, and means that the patient always has the role of the expert in his or her own life, while the therapist's role is as much as possible about supporting processes wherepatients can explore, experience, make choices and take steps in line with their values.

Treatment Content at the Unit

Medication free services shall be based on national guidelines (Norwegian Directorate of Health, 2013), which recommend measures such as conversation therapy, family collaboration, music therapy, physical activity, social skills training and measures aimed at helping the patient in work or education. The treatment at the MFBT inpatient unit has been developed in line with these guidelines, based on daily group activities consisting of physical activity, art therapy and Recovery Workshops. The patient can also, if necessary, receive individual treatment measures from an experienced consultant, psychologist, physiotherapist, etc. The unit is structured and set up as a working day, with treatment from morning until dinner. The planned admissions to the unit provide an opportunity to work therapeutically with specific challenges. The environment at the inpatient unit is considered as an arena for receiving support/guidance to work with individual recovery goals.

Weekly Programme. The treatment programme at MFBT is based on planned group activities; groups and meals happen together, at the same time as treatment is individually adapted to the patient and there are opportunities to do something else if a group or activity seems too demanding. The unit is structured around a culture and environment where everyone is together, both patients and staff. This is done to facilitate the creation of inclusive and equality-based experiences and conversations. There is also room to be alone with oneself and choose to be social according to what one feels. The treatment programme contributes to the structure of everyday life at the unit and can be a starting point for exploring what the patient can acquire and use in everyday life at home.

All the activities on the schedule can function as an arena where the patient can explore and practice individual recovery goals, and be set up within networks or teams. For example, a patient may desire to speak in a group, practice concentration, have something to stand up for, improve physical health or practice being in a conversation with others while experiencing auditory hallucinations.

SThe weekly programme contains 5 different groups/activities as follows: Recovery Workshop; mindfulness; creative workshop; recovery through music; and physical activity.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
08.00	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast		
08.15	Employees meeting	Employees meeting	Employees meeting	Employees meeting	Employees meeting		
08.45	Daily meeting	Daily meeting	Daily meeting	Daily meeting	Daily meeting		
08.55			Whiteboard meeting				
09.05	Mindfulness exs.	Mindfulness exs.	Mindfulness exs.	Mindfulness exs.	Mindfulness exs.		
09.30	Physical exercise group	Recovery workshop group	Physical exercise group		Physical exercise group		
10.00							
10.30							
11.00	Lunch	Lunch	Lunch	Lunch	Lunch		
11.30							
12.00		Art therapy group	Recovery workshop group	Recovery workshop group	Recovery workshop group		
12.30							
13.00							
13.30							
14.00							
14.30					Sweet end of the week		
15.00							
15.30							
16.00	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
16.30							
17.00							
17.30							
18.00							
18.30							
19.30	Supper	Supper	Supper	Supper	Supper	Supper	Supper
20.00							
20.30							
21.00							

Recovery workshop. The Recovery Workshop is a group-based treatment lasting for one hour, four days per week. It is a group, in which both patients and staff participate. The purpose of the Recovery Workshop is to increase awareness of one's own health and life situation, which increases the probability of perceived mastery and self-care. Self-management and self-care are key to the recovery perspective, where the goal is to give people the opportunity to seize their own process or regain control of their own lives.

For each week, there is one recurring theme for the four sessions. In the first session, this theme is linked to the concept of recovery and recovery processes.

Recovery is both a personal and a social process and involves working with hopes and dreams to live a meaningful life. Here, the focus is on coping with mental health problems and symptoms, and what one can do to be better, with oneself, and in the context in which individual lives are lived. In the Recovery Workshop, this is done through a combination of teaching, group reflection, dialogue, and sharing different forms of knowledge.

The Recovery Workshop takes its inspiration from the Illness Management and Recovery (IMR) programme (Mueser, 2006) and many of the themes in the Recovery Workshop coincide with those covered in the IMR programme. Dialogue and sharing of experience are largely facilitated in this offer, more than the dissemination of knowledge through traditional teaching and lecturing. Nevertheless, whiteboards are used extensively to keep focus and reflect together on the week's theme.

Compared to the IMR programme, our Recovery Workshop is not manual-based and structured, and it places greater emphasis on dialogue and group reflection here-and-now rather than on individual tasks during the sessions and between the sessions. The experiential knowledge that both patients and staff bring to the workshop is emphasised, valued and given a lot of space. In this way, the Recovery Workshop is probably more akin to a Recovery College as it was developed with origins in England (Perkins, 2018). At a Recovery College, emphasis is placed on experiential knowledge on an equal footing with theoretical knowledge. Those who participate in these courses are participants and not patients; they are not referred by others, but register themselves for these courses. The courses offered at a Recovery College are relevant to the general society and focus on how everyday life can be lived with the challenges the individual has. The IMR programme relies on a traditional understanding of ‘illness’ to a greater extent and focuses, with a stronger emphasis on understanding the management of related symptoms.

Experiential knowledge has a large place in our Recovery Workshop and it is encouraged that those present, both patients and employees, share their thoughts and experiences related to the relevant topics. The themes are, with some exceptions, largely universal and commonplace. Examples of such topics are: Sleep, Diet, Physical Activity, Everyday Life and Coping, Dreams and Responsibilities, What is Normality? Coping and meaning, Anxiety, Freedom and

life, How to take care of oneself, My flock, Getting to know oneself, Emotions and emotion regulation, Spirituality, faith and existence. Examples of more specific topics are: Hearing voices, Medications and Mental health conditions, Crises and coping plans, Shared reading.

Mindfulness. Mindfulness exercises take place every day from 09:05-09:20. The group is led by an employee of the Unit. The purpose of this exercise is to familiarize with one's own breathing, become confident in sitting in a group with closed eyes, realize one's feelings and thoughts in an accepting/mindful way, and to experience one's own body and the connection it has with both breath, emotions, thoughts, and surroundings. After each session, anyone who wants shares how it felt to be in the group and we shortly discuss what will happen on that day.

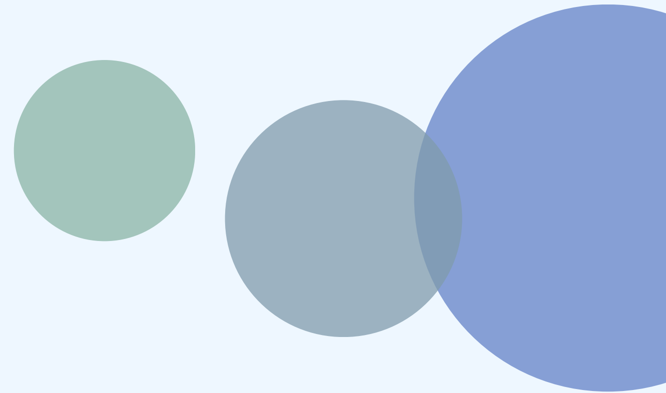
Creative group. The unit has a creative group once a week, and the group is led by an employee with an education in art and expression therapy.

Art therapy is to express oneself through creativity. Creating an expression, such as an image, can be a way to put ‘words’ into thoughts and feelings. When you create something with your hands, words are not needed, the words come afterwards. Pictures, colours and symbols can tell a story. Creating can help you discover resources you did not know existed. The images can also be relieving by expressing something you did not know you had inside you. It does not matter what you create or whether you are good at drawing.

Recovery through music. This group is held once a week and is led by a music therapist. Music is the starting point for this activity session. You listen to music suggested by the leader of the group or at the request of participants in the group, and you share your thoughts and feelings about what music means or does to you as an individual.

Physical activity. The programme includes physical exercise, in groups, planned 3 days a week. The exercise is arranged so that everyone can participate. Two of the days the training takes place in the gymnasium as strength training. One of the days is set up as an outdoor cardio training.

After dinner, there is free time in the unit. The employees who are at work are available for the patients and offer activities, conversations and follow-up based on individual needs and treatment plans. The unit wants to be a friendly space and always has different projects that take place jointly between patients and staff. These can be small everyday activities such as walks in the mountains and fields, ice swimming, concerts and cinema, but also larger projects such as arranging a music festival for the entire hospital. The purpose is to create arenas for togetherness and mastery by testing-out new things and having new experiences. Such activities are relationship-building, both between patients and staff, and among patients.



Medication Reduction – Tapering

Medication-free treatment is offered to people with severe mental health conditions, who want to achieve a medication-free life. Nevertheless, about half of the patients do use medications at the time of their hospitalisation. These patients want help to reduce their neuroleptics (or so-called mood-stabilising drugs). There is a lack of knowledge on maintenance treatment with neuroleptics beyond 2 years (Harrow et al., 2013, 2021). Despite this, many patients remain on these drugs for many years. Knowledge about the reduction/tapering of medications used for psychosis and bipolar disorder is also lacking. Training in the reduction of these medicines is completely absent in psychiatrists and health professionals' education institutions. Gradually reducing the doses of these drugs, especially after a long-term use, is far more problematic than what prescription instructions, professional guidelines or professional literature describes. Experience shows that among other things, completely new ailments may develop during attempts at reducing such medications.

User organisations and interest groups for people with mental health conditions, however, have known this for a long time. This led to users of these medicines

taking various initiatives to gather and disseminate experiential knowledge on how to gradually reduce doses of psychotropic medication. One example of this is the "Harm reduction guidelines to quit or use less psychotropic drugs", which was first published in 2007 in English by Will Hall and The Icarus Project. These guidelines were translated into a number of languages as a collection of people's experiences and practical advice for reducing or tapering psychotropic drugs. "The Inner Compass Initiative" is a website run by people with their own experiences of reducing doses of psychotropic drugs. The website contains advice on how to proceed when phasing out medicines, including concrete and detailed descriptions of how you can modify medication doses yourself. Both of these initiatives are examples of how valuable users' knowledge coming from personal experience is. They gathered and made this knowledge available when this has been manifold in the field in general.

The Norwegian Psychiatric Association published Clinical advice for phasing out and discontinuation of antipsychotic drugs in 2020. Here they acknowledged that tapering and discontinuation of so-called antipsychotic drugs can be very demanding and that there is limited knowledge about this process. They also added a list of tapering symptoms and recommendations to map these during tapering. A tapering step of 10-25% of the initial dose every 2-3 months is recommended.

An article published in 2021 by Horowitz et al. describes a method for reducing neuroleptics. Here it is suggested that the closer one gets to complete discontinuation of the us of antipsychotics, the dose should be reduced with a smaller and smaller percentage. It proposes a 5-10% reduction of the last dose of antipsychotics every 3-6 months. The last dose before discontinuation may then be as small as 1/40 of the original dose. The chances of withdrawal symptoms are reduced when using this strategy. In order to be able to implement such a reduction regimen, there will be a need for medication in far more and smaller doses than what is currently available through ordinary doses in drugstores.

In the Netherlands, in a collaboration between patients, researchers, and a pharmacist, tapering strips have been developed that enable a far more gradual reduction of psychoactive medicines than ordinary medicine doses allow. Since the first tapering strip was available in 2013, this solution is currently available

for 49 different psychoactive drugs. For a short period in 2019-20, it was possible to import tapering strips to Norway. However, this possibility of import was stopped by the Norwegian Medicines Agency in 2020, allegedly due to an export ban in the Netherlands. The availability or production of such tools in Norway is necessary to help more people to succeed in phasing out psychotropic drugs.

Elements that the unit considers for tapering:

- What previous experiences does the patient have with tapering and discontinuation?
- Timing. Is this the right time to start a reduction? Is life otherwise stable in terms of housing, finances, networks and relationships, activity, education or work?
- Is there support in your own network, both private and public, for tapering?
- Has an emergency plan been prepared that describes possible deterioration and what can be done to prevent and deal with this? What ailments can be expected to appear? Will the ailments that initially led to the start of the medication reappear? In this case, how should this be handled without medication?
- At what speed should tapering occur? Prepare for possible challenges and symptoms/new ailments and the need for breaks in tapering and adjustment to the reduction plan.
- How should one's basic needs for nutrition, sleep, rest, exercise be attended to?
- Considering the needs of a place to live, work or money to live on, something to do, someone to do it with.

Experiences, thus far

The medication free treatment programme has now been in operation for almost 5 years. At the time of writing, approximately 80 people overall have received treatment courses at the unit. The organisation has the possibility of running around 30 different active patient courses, where people in such treatment courses also receive treatment from services at their local district psychiatric centre and at planned admissions to the unit.

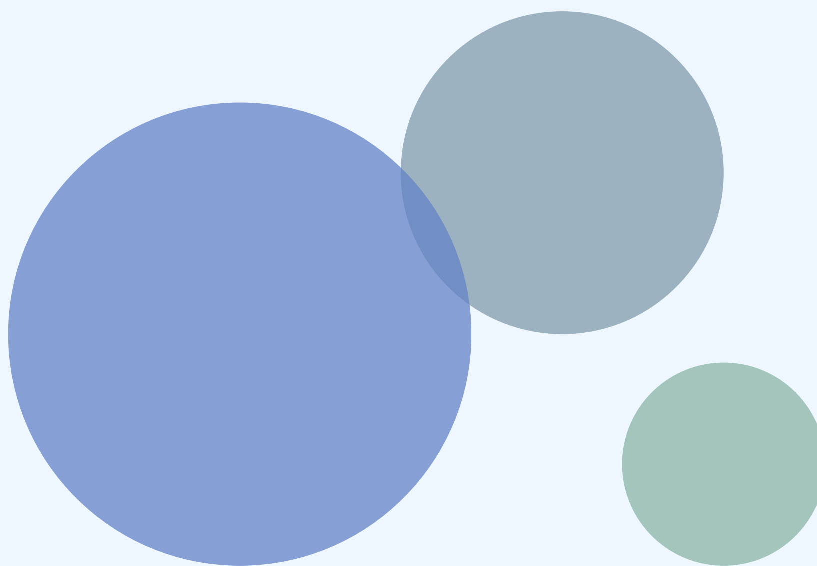
2/3 of those who have come to the unit have been women, 1/3 – men. The age range has varied between 19 and 63 years. The number of referrals has been fairly evenly distributed over the years. Over half of those who were referred have a persistent psychosis problem as a reason for referral, the rest have a diagnosis within the bipolar spectrum. The vast majority have other additional diagnoses. People with ongoing drug addictions are not offered treatment at the Unit. Virtually everyone who has been in the process has had previous admissions to mental health care in Norway, a very high proportion have compulsory experiences, both in the form of involuntary admissions and compulsory medication treatment with neuroleptics.

As the course is created and established on the basis of what is best for the individual patient, there is great variation in the number of admissions and the length and content of the admission. The number of admissions has thus varied between 1 and 26, and the length of the admission has varied between 1 day and 1 year. The most common, however, are planned admissions of 2 weeks, 1-3 times in six months during the period you are in an active course of treatment.

In relation to the use and tapering of neuropleptics, almost all patients who have come to the unit have previous experience with the use of neuroleptics. At the time of referral, approximately half have used neuroleptics regularly. The remaining half had previous experience with neuroleptic use, but had already stopped taking it on their own before the admission. The remaining group wanted assistance from the unit to reduce their medication use. Our experience shows that tapering and being able to live without medication, especially when you have used medication for a long time, can be a very demanding and lengthy process. Especially in situations where a person uses several different types of

neuroleptics, the tapering process can extend over several years. Slow dose reduction can reduce the risk of tapering symptoms. Nevertheless, perhaps the most important part of this process are the psychological processes that take place in connection with painful and demanding inner experiences becoming more accessible and sought to be handled in other ways without the use of medication.

Medication free treatment is available at the Unit, but it is still in a developmental phase.Collaboration with the patients and their networks that have taken place at the unit has contributed to an increase in professional experience and competence. Experiences are gathered along the way, mainly via dialogues, and are used for continuous development with the patients being in focus. We hope that the treatment programme can meet the expectations for the unit contributing to better knowledge and further disseminating such experiences. The unit prioritises participating in dissemination of the treatment and experiences in various professional forums, in addition to various dialogues with interest organizations and international organizations. There is great international interest in medication free treatment, also in the general media.



Quotes

From the BBC-paper and radio programme:

"I feel like for the first time ever I'm starting to find myself. I'm starting to build up my self-esteem and I can dare to feel some hope for the future, and that is pretty amazing."

"I'm trying to reconnect with my emotions instead of dulling down the symptoms. We explore what this voice wants and what do I need for him to stop?"

From a paper in Sinn og Samfunn:

"Here I get to work with emotions in a safe environment. At home, I must be able to take my life back."

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